

Patient Name: _____

Date: _____

INSTRUCTIONS: Using the “Scale of Symptom Points” listed to the right, score every symptom based on your experience OVER THE PAST 30 DAYS, then subtotal each category. Add the subtotals and record the “Grand Total” at the bottom of the form.

Scale of Symptom Points

Leave blank if you DID NOT experience the symptom
 1 = Mild and Occasional (less than 2 times per week)
 2 = Mild and Frequent (2 or more times per week)
 3 = Severe and Occasional (less than 2 times per week)
 4 = Severe and Frequent (2 or more times per week)

CONSTITUTIONAL

Fatigue _____
 Hyperactive _____
 Restless _____
 Daytime sleepiness _____
 Insomnia at night _____
 Malaise (feeling lousy) _____
 Seizures _____
TOTAL (0-28) _____

EMOTIONAL/MENTAL

Depression _____
 Anxiety _____
 Mood swings _____
 Irritability _____
 Forgetfulness _____
 Lack of concentration _____
 Brain fog _____
 Low sex drive _____
TOTAL (0-32) _____

HEAD/EARS

Headache (not migraine) _____
 Migraine _____
 Earache _____
 Ear infection _____
 Ringing in ears _____
 Itchy ears _____
 Discharge from ears _____
 Sensitivity to sound _____
TOTAL (0-32) _____

SKIN

Blemishes, acne _____
 Rashes or hives _____
 Eczema _____
 Psoriasis _____
 “Rosy” cheeks _____
 Flushing _____
 Itchy skin _____
TOTAL (0-28) _____

NASAL/SINUS

Post nasal drip _____
 Sinus pain _____
 Runny nose _____
 Stuffy nose _____
 Sneezing _____
TOTAL (0-20) _____

MOUTH/THROAT

Sore throat _____
 Swollen throat _____
 Burning lips/tongue _____
 Swelling lips/tongue _____
 Gagging/throat clearing _____
 Canker sores _____
 Difficulty swallowing _____
TOTAL (0-28) _____

LUNGS

Wheezing _____
 Chest congestion _____
 Dry cough _____
 Wet cough _____
 Shortness of breath _____
TOTAL (0-20) _____

EYES

Red or swollen eyes _____
 Watery eyes _____
 Itchy eyes _____
 Dark circles or “bags” _____
 Sensitivity to light _____
 Aura _____
TOTAL (0-24) _____

GENITOURINARY

Increased urinary frequency _____
 Painful urination _____
 Bladder pain _____
 Bedwetting _____
TOTAL (0-16) _____

MUSCULOSKELETAL

Joint pains _____
 Stiff joints _____
 Muscle aches _____
 Stiff muscles _____
 Tics (facial or otherwise) _____
 Muscle spasms _____
 Muscle cramps _____
TOTAL (0-28) _____

CARDIOVASCULAR

Irregular heartbeat _____
 High blood pressure _____
TOTAL (0-8) _____

DIGESTIVE

Heartburn/reflux _____
 Stomach pains/cramps _____
 Intestinal pains/cramps _____
 Constipation _____
 Diarrhea _____
 Bloating sensation _____
 Gas (of any kind) _____
 Nausea _____
 Vomiting _____
 Painful elimination _____
TOTAL (0-40) _____

WEIGHT MANAGEMENT

Current weight: _____
 Fluctuating weight _____
 Food cravings _____
 Water retention _____
 Binge eating or drinking _____
 Purging (all methods) _____
TOTAL (0-20) _____

GRAND TOTAL _____